Office Use: Client Name: _____________ ______________D.O.B. ___________ Record #___________

Therapeutic Solutions Professional Counseling Group
201 S. McPherson Church Rd, Suite 202
Fayetteville, NC 28303
Office: 910-916-6657 fax:910-920-2420

Date:_____________________

CLIENT INFORMATION

Client's First Name_________________________Last Name:____________________ Middle:____________________

DOB:___________________ Age:_____ Gender:☐Male☐Female Race/Ethnicity:________ SS# ________________

Address: ____ City: ______________________ State: _______ Zip: _____________

Telephone (Home)___________________________(Work)______________________ Cell#: ____________________________

Best Contact Number:________________________________ May we leave a message? ☐Yes ☐No

Email address for appointment reminders, newsletters and cards: ____

Occupation: ___________________________________ Employer: ____

How long have you worked there?__________________ Address of Employer____________________________________

Phone number of employer:_______________________School:______________________________Grade:________

Military? Active Duty/Veteran/Retired Military/Spouse/Child/Significant Other (Please Circle All that Apply)

PARENT/GUARDIAN INFORMATON (IF APPLICABLE)

Who has custody of minor?____ (Please provide custody papers or MOA)

If child is in Foster/Group Home list here: (Name of Facility) _________________________________

Facility Address:____

Name of Parent/Guardian: _______________________________ Relationship to client: ___________________

Address______________________ City________________State:_____Zip:_________________Phone#: _________________

INSURANCE/PAYMENT INFORMATION

Person Responsible for Payment: _______________________________ Relationship to client: _____________________________

Primary Insurance____Secondary Insurance: _____________________________

Policy/ID#:__________________________________ Policy/ID#: _____________________________________

Subscriber SS#_________________Group #_____________ Subscriber SS#_________________Group #_____________

DOB of Subscriber:___________________________________DOB of Subscriber:___________________________

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EMERGENCY INFORMATION: In case of emergency, contact:

Name (1): ________________________________ Relationship: _________________ Phone: ____________________

Address: _______________________________________ City: ______________________ State: N.C. Zip: _________________

Name (2): __________________________________ Relationship: _________________ Phone: ____________________

Address: _______________________________________ City: ______________________ State: N.C. Zip: ________________

Primary Care Physician: ____ Phone: ________________________________

Address: _______________________________________ City: _______________________ State: N.C. Zip: _______________

Psychiatrist: _______________________________________

Hospital:____

MEDICAL INFORMATION

Medical Issues: ____

Current Medications:____

____

Allergies:____

WHY ARE YOU HERE TODAY?

____

____

PREVIOUS COUNSELING/PSYCHIATRIC TREATMENT:

Name of Therapist/Psychiatrist:____ Last Seen: _______________________

Name of Therapist/Psychiatrist:____ Last Seen: _______________________

Length of Treatment: ____

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REFERRAL SOURCE:

How did you hear of our agency (or from whom)?:____

Address: ____ City: _______________________ State: N.C. Zip: _______________

Relationship to referral source: ______________________________

May we send them a thank you card; not including your name?____________________________

AGENCY INVOLVEMENT

Court status: ☐ None ☐ Court ordered ☐ Court involved ☐ In custody ☐Probation; PLEASE EXPLAIN:______________________

____

Therapeutic Foster/Group Home Agency:___________________________ Address:____________________________

DSS status: ☐No ☐Yes DSS Worker: _________________________ Phone Number: _____________ County:______________

Guardian Ad Litem Name: _____________________ Court Counselor Name:_________________________ Probation Officer Name: __________________ Phone Number:_______________________

PLEASE EXPLAIN STATUS HERE: ____

____

____ ______________________________

Signature __Client __Parent/Guardian __Personal Representative____ Date

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HEALTH INSURANCE PORTABILITY AND ACCOUNT ABILITY ACT

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this Office such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a Client cannot be shared with another party without the written consent of the Client or the Client's legal guardian or personal representative. It is the policy of this Office not to release any information about a Client without a signed release of information except in certain emergency situations or exceptions in which Client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a Client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the Client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

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Abuse
If a Client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a Client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of Clients when a Court Order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor Clients have the right to access the Client's records.

Other Provisions
When payment for services are the responsibility of the Client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the Client's credit report may state the amount owed, the time-frame, and the name of the Office or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the Client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

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Information about Clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the Client, or any identifying information, is not disclosed. Clinical information about the Client is discussed. Some progress notes and reports are dictated/typed within the Office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the Office or mental health professional must telephone the Client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $ .25 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

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If you desire a written copy of this notice you may obtain it by requesting it from the Office at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the office. We will get back to you in a timely manner.

201 S. McPherson Church Rd
Suite 202
Fayetteville, NC 28303
910-916-6657

You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the perspective board of your acting therapist at **North Carolina Board of Licensed Professional Counselors or North Carolina Certification and Licensing Board or North Carolina Marriage and Family Therapy Licensure Board** . If you are unsure please asks us. If you file a complaint we will not retaliate in any way.

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications**.**
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _______________________________________ DOB: _______________
(Client)
Signature____
(Parent/Guardian/Client)
Print Name (if different from client)_____________________________________

Date___________________________

Sessions and Length

The first session/assessment is approximately 75 minutes in length. Subsequent counseling sessions are 45 minutes in duration.

Cancellations/ Missed Appointments/ Late Cancellations:

Please **call** 24 hours in advance to cancel or reschedule appointments. This gives the company an opportunity to offer the appointment time to someone that would like to come in. **An $85 missed appointment/ late cancellation fee will be charged to your account or card after your 2nd failure to give 24 hour notice.** We know that emergencies occur, however, please be considerate of our time. Please understand that missed appointments cannot be billed to insurance. **If three or more appointments are missed or cancelled late, you may be required to obtain services from another provider.** It is required that you provide your Visa or

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Mastercard information below that will be charged in the event that of 2 no shows or late cancellations. **Fee not applicable to Military One Source and Medicaid clients.**

Name as it appears on your card:______________________________

Card Number:______________________________ Date on Card:____________

Security number (3 digits) on back of the card:_____________________

Fees/Payment/Insurance

Initial meeting/assessment- $125 for 60-75 minutes
Individual Counseling- $85 for 45 minutes
Family counseling- $95 for 45 minutes; Returned Checks-$30; Cash, Visa, Mastercard, Flexible Spending Cards, and personal checks are accepted. Payment is expected at the time of service. After one returned check you will be required to make all payments by cash or money order. Make checks payable to Therapeutic Solutions Professional Counseling Group.

Full payments and/or co-pays are due at the time of service. Patients will be responsible for all charges not covered by their insurance company. **Primary and Secondary Insurance**- you must provide this information prior to the service being rendered. It is your responsibility to know the provisions of your policy and status of your insurance. Please notify this office as soon as possible of any changes in your insurance coverage or change of insurance carriers.

The fee for these professional services, consultations, reports, and letters is $85 per hour. Copies made of requested information is 20 cents per page.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time at a rate of $85 per hour, including preparation, my time waiting and transportation time and costs, even if I am called to testify by another party. We do not get involved in testifying in child custody cases. If this will be an issue it may be best to find another therapist.

Client Printed Name:______________________________________

Client Signature:____________________________________ Date:___________________

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CONSENT TO TREATMENT AND RECIPIENTS RIGHTS

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at **Therapeutic Solutions Professional Counseling Group,** agree to abide by the above stated policies and agreements. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Office encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received/read the Recipient's Rights and certify that I understand its content.

Non-Voluntary Discharge from Treatment: A Client may be terminated from the Office non-voluntarily, if: A) the Client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Office, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The Client will be notified of the non-voluntary discharge by letter. The Office will assist with referral if needed.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Office is protected by Federal and/or State law and regulations. Generally, the Office may not say to a person outside the Office that a Client attends the program or disclose any information identifying a Client as an alcohol or drug abuser unless: 1) the Client consents in writing, 2) the disclosure is allowed by a Court Order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program
evaluation.

Violation of Federal and/or State Law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a Client either at the Office, against any person who works for the program, or about any threat to commit such a crime. Federal Law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a Client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor Clients have the right to access the Client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

____ ___________________________

Signature of Client/Legal Guardian/Representative **Date**

____ ___________________________

Signature of Client/Legal Guardian/Representative **Date**

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DISCLOSURE OF CONFIDENTIAL INFORMATION

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

I, ___________________________________ authorize ***Therapeutic Solutions Professional Counseling Group*** **to** use or disclose to/with

____.

(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to **initial** beside data to be used or disclosed)

____ Assessments _____ Service Notes ___ Substance Abuse/Treatment
____ Psychiatric Evaluations _____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis _____ Discharge Summary ___ Social History
____ Developmental History _____ Financial/Reimbursement ___ Medical History
_____ PCP _____ Other: ______________________________

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)

_____ At the request of the individual _____ Assessment/Evaluation _____Spanish Interpreter
_____ Coordination of Service ____ Court Proceedings _____ Determination of Benefits

Information requested should be mailed to this address or faxed: Therapeutic Solutions Professional Counseling Group
201 South McPherson Church Road, Suite 202
Fayetteville, NC 28303
(phone) 910-916-6657 (fax)910-920-2420

REDISCLOSURE:

Since information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Area Program/LME's Notice of Privacy Practices, a copy of which has been given to me. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:
(Date of expiration, if less than one year) (Event, if less than one year)

Notice of Voluntariness:

I understand that I may refuse to sign this authorization form. I understand that **Therapeutic Solutions Professional Counseling Group** will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

(Initial one): A photocopy of this authorization ________ MAY ________ MAY NOT, be considered as valid as the original.

____ ______________________
Signature of Client Date

____ ____________________ ______________________
Signature of Legally Responsible Person (when required) State Relationship to Client Date

____ ______________________
Signature of Witness Date